

REPORT DOCUMENTATION PAGE				Form Approved OMB No. 0704-0188	
Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0188), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.					
1. REPORT DATE (DD-MM-YYYY) 16-05-2003		2. REPORT TYPE FINAL		3. DATES COVERED (From - To)	
4. TITLE AND SUBTITLE A JOINT MEDICAL COMMAND AND TRANSFORMATION				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S) Rey Conard Paper Advisor (if Any): CAPT Robin Babb				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Joint Military Operations Department Naval War College 686 Cushing Road Newport, RI 02841-1207				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES) Joint Military Operations Department Naval War College, Newport, RI 02840				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION / AVAILABILITY STATEMENT Distribution Statement A: Approved for public release; Distribution is unlimited.					
13. SUPPLEMENTARY NOTES A paper submitted to the faculty of the NWC in partial satisfaction of the requirements of the JMO Department. The contents of this paper reflect my own personal views and are not necessarily endorsed by the NWC or the Department of the Navy.					
14. ABSTRACT This paper examines the establishment of a Joint Medical Command. It provides some brief historical notes. It discusses the readiness mission and interrelated benefits mission. It relates the advantages to the operational commander of transforming the Medical Health System to a joint command from the perspective of the principles of war. The paper notes previous objections raised and recommends establishment of a Joint Medical Command with individual Service components along the lines of USSOCOM. A further recommendation is, in order to meet growing asymmetric threats, greater reliance should be placed on military medicine as opposed to civilian contractors.					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES 21	19a. NAME OF RESPONSIBLE PERSON Chairman, JMO Dept
a. REPORT UNCLASSIFIED	b. ABSTRACT UNCLASSIFIED	c. THIS PAGE UNCLASSIFIED			19b. TELEPHONE NUMBER (include area code) 401-841-3556

Standard Form 298 (Rev. 8-98)

NAVAL WAR COLLEGE
Newport, RI

A JOINT MEDICAL COMMAND AND TRANSFORMATION (U)

by

Rey Conard, CDR, USN

A paper submitted to the Faculty of the Naval War College in partial satisfaction of the requirements of the Department of Joint Military Operations.

The contents of this paper reflect my own personal views and are not necessarily endorsed by the Naval War College or the Department of the Navy.

Signature: _____

16 May 2003

Robin Babb: _____
CAPT, USN

Table of Contents

• Introduction	1
• Transformation	3
• Historical Consideration & Recommendation for a Joint Medical Command	3
• Dual Mission for Military Health Systems	7
• Cost factors of Military Health System versus private health care system	8
• Advantages of transforming to a Joint Medical Command-the readiness mission	9
• Arguments Against and Proposed Structure of a Joint Medical Command	14
• Recommendations	17
• Conclusions	18
• Appendix A	24

A JOINT MEDICAL COMMAND AND TRANSFORMATION

Introduction:

This paper addresses the issues of the readiness mission of the military health system (MHS) as well as the intertwined benefits mission. It examines how the establishment of a Joint Medical Command would be useful for the geographic commanders in the current environment of transformation. It also examines the issue of reliance upon military medicine versus greater reliance on privatization from the perspective of the geographic commanders in meeting their multitasked missions.

The objective given to the MHS is to preserve the fighting strength of the force. As with all other aspects of the art of warfare, operational factors of time, space, and force, as well as information must be considered.¹ The space begins at the point of wounding or becoming ill. Information must be relayed about the event to enable the skilled force necessary to render aid. Time is critical to save life for the wounded and contain the threat of illness in the case of a chemical, biological, or radiological event. The operational commanders are keenly aware of the importance of medical support and it is incumbent upon the MHS to make the system as responsive as possible to the commanders needs.

Most large corporations and government organizations have a managed health care plan available for their employees. The most common form is a health maintenance organization (HMO), where all services are delivered and paid for through one organization.² The costs of these plans have been rising rapidly for many years. Rate increases are expected to continue.³ The military is both a large consumer and provider

of health services. Just as with the rest of the country, health care costs have been rising for many years and the rate increases may continue. However, a military health system using a concept of transformation, exploiting information technology to reform business practices, is favorably positioned to address the issue of rate increases to the benefit of the military and those utilizing its health care services.

The military health system is often compared to private industries' HMOs and no doubt can benefit from corporate America's experience. However, unlike most large corporations, the military is invested with a special trust – to protect our citizenry from all enemies foreign and domestic. It is given a mission that if failed would result in great loss of life and a radical change in the way of life for the survivors. In keeping with that trust, our troops are relatively well paid, and they are given the best training and the best equipment we can afford. Military medicine is similarly bound to that same special trust. The military health system (MHS) is called upon to perform some unique and some routine health care tasks. The bottom line for the MHS is that failure is not an option. There are costs built into the system that a for-profit private health care organization does not pay. Examples of such costs would be the cost of deployment and the cost of strictly military training for MHS personnel as opposed to medical training.

Over the years, there has been a great deal of concern expressed about the MHS revolving around two basic issues; cost and readiness.⁴ Over the past five decades, the U.S. military has learned that a very productive way to approach large complex issues is to operate jointly.⁵ That experience has led to our current actions towards transformation.

Transformation

In April 2003, the Department of Defense (DoD) issued a document entitled Transformation Planning Guidance (TPG). In it, Secretary of Defense Donald H. Rumsfeld stated “that the war on terrorism is a transformational event that cries out for us to rethink our activities and to put that new thinking into action”.⁶ Further, Mr. Rumsfeld noted that the outcome we must achieve in transformation will be: “fundamentally joint, network-centric, distributed forces capable of rapid decision superiority and massed effects across the battlespace.”

Consistent with this view, a senior Navy leader emphasized that the Navy plans to become fully joint in outlook, surge ready and able to present the senior leadership with options to meet any threat to the United States.⁷

The threats the military health system may confront in the future not only encompass conventional armed conflict as recently experienced in Afghanistan and Iraq, but may well include attacks using biological, chemical and nuclear weapons on U.S. citizens at home and/or abroad. Due to the inherent nature of such an attack and the potential for mass casualties, the U.S. Military Health System, as one of the largest health care providers in the nation and holding the special trust of protecting our citizens, will almost undoubtedly be called upon and expected to perform quickly with a very high level of expertise. To quote Lieutenant General Ronald R. Blanck, former Surgeon General of the U.S. Army, “Civilians expect that we in the military will know how to manage chemical and biological casualties. Indeed, if we do not, then who will?”⁸

Historical Considerations & Recommendations for a Joint Medical Command:

The concept of a joint medical command for the military services was first proposed in 1949 by the Chief of Staff of the U.S. Army, General Dwight D. Eisenhower, who wrote to the Secretary of Defense “. . . immediately institute studies and measures intended to produce, for the support of the three fighting services, a completely unified and amalgamated (single) Medical service.”⁹ The idea was not implemented but has come up many times since that time. The fact that the idea has resurfaced many times is a testament to its appeal to some and to its lack of appeal to others.

Joint effort is nothing new to the Military Health Services. For example, in World War II the hospital ship, USS COMFORT II, operated with a Navy crew and Army Medical personnel. The ship evacuated wounded from Leyte, Philippines and Okinawa, Japan where she was struck by a Japanese suicide plane on 29 April 1945 which killed 28 persons (including six nurses), injured 48 others and caused considerable damage.¹⁰

Current day examples of MHS working jointly along strictly functional lines include the Armed Forces Institute of Pathology, the Armed Forces Blood program, and the Armed Forces Medical Intelligence Center.¹¹ Other more general examples of the military health services working jointly include Uniformed Services University of the Health Services medical school, and the Walter Reed Army Medical Center and Bethesda Naval Hospital cooperating extensively in the training of medical personnel and caring for patients. The Strategic Medevac system which transports sick and wounded service members is operated by the Air Force. All services use helicopters to move troops from the field or ship to a land or sea based medical facility. Again, the Medevac system serves all branches of the military services. The Army is typically tasked with providing helicopters to move casualties from field hospitals or aide stations to Navy operated

hospital ships. In the recent conflict in Iraq, the Marine Corps also participated in this mission. The U.S. Naval Hospital, Okinawa, Japan, is the fourth largest U.S. Naval Hospital. U.S. Naval Hospital, Okinawa features a first rate neonatal intensive care unit which serves the entire western Pacific and it is staffed and funded by the Air Force. A final example is that all military treatment facilities (MTFs) today serve all military services, their dependents, retirees and all Tricare eligible beneficiaries. The point of these examples (and this is by no means an exhaustive list) is that born of necessity at the tactical and operational level, the MHS is working jointly now. However, at the higher joint operational and strategic levels of command no similar joint level of organizing, planning and execution is in place. The geographical commander must approach each service individually to determine capability and availability of medical assets to support their operations.

According to a RAND study of Reorganizing the Military Health System published in 2001, “The National Defense Authorization Act for Fiscal Year 2000 requested that the Secretary of Defense submit a study identifying areas with respect for which joint operations might be increased, including organization, training, patient care, hospital management, and budgeting.”¹² The study noted that prior to their research and since the initial recommendation by General Eisenhower, there had been at least 13 studies of the military health services. Six of these studies recommended adding to the Central Authority to improve coordination among the services and four studies recommended creating a unified service.

The RAND study recommended consideration of five different command structures. Included were three which would be variations of a Joint Medical Command.

The authors noted that “There is no guarantee that a joint command would succeed in solving the persistent performance and cost problems that motivated the many studies of MHS organization, including this one. However, a joint command would “put someone in charge” of military health, a step most DoD senior officials advocated during the interviews conducted for this study.”¹³ This author found the same complaint (no one’s in charge) echoed by all senior medical officers interviewed for this paper.

The KPMG Consulting presentation to the Defense Military Oversight Committee, DMOC III on 21 March 2001, explored five models of Joint Command proposals.¹⁴ The presentation included the following joint command Pros and Cons:

Positives	Negatives
<ul style="list-style-type: none"> • Single Advocate and point of accountability to lead for readiness and benefits mission • Increased unity of effort in and among Services and markets • Coherent command structure • Enhanced ability to optimize MHS assets • Enhanced ability to plan for theater requirements as opposed to just Service requirements • Better alignment with upcoming QDR • Unified Service voice to communicate funding and benefits issues to Congress and respective military departments 	<ul style="list-style-type: none"> • Significant change from status quo • Significant implementation issues and barriers • Legislation required • Service Components’ Title X may dilute “CINCMED’s” authority • “CINCMED’s” authority may dilute Service flexibility • Few Joint Service qualified personnel • Rotation policies for key positions may detract from longer tenure of high performers

Dual Missions of the Military Health Services:

The Military Health Services have two missions:

1. The benefits mission is to provide for medical services to active duty service members, their dependents, retirees and all eligible Tricare beneficiaries.
2. The readiness mission is to maintain military readiness and to provide medical services and support to the armed forces during deployments.¹⁵

There are some who argue that the MHS should focus primarily on the readiness mission and contract out the benefit mission to independent contractors or to form a Federal HMO. Colonel David Wherly stated that “realistic military medical readiness training is a rare occurrence for HSS (health services system) personnel. For most of today’s HSS forces, the notion that readiness requires one to organize and train in peacetime as you intend to go to war is outside their conceptual paradigm.”¹⁶ However, the training and maintenance of medical skills require a large number of patients with the widest possible mix of conditions. The military cannot wait for the next war, terrorist attack or humanitarian operation to train its personnel. The mix of training is continually reviewed and improved, but it is difficult to imagine meaningful training without patients.

The readiness mission and benefits mission are mutually beneficial in at least three ways. First, the MHS obtains the patients needed for training and maintaining skills and the beneficiaries obtain medical care. Second, there is the matter of cost which is less if care can be provided in the military treatment facility. For example Lt. General Paul K. Carlton (former Surgeon General of the Air Force) stated that an operation performed on base would cost \$300.00 (the cost of a surgical pack). On the outside, the same procedure will cost DOD \$ 6,000.00.¹⁷ Besides the monetary cost there is also the fact

that each time a patient is sent to an outside provider there is another training case lost. Third, one of the most effective tools the military has for attracting some of the best and brightest medical minds is by offering training programs in exchange for a period of service. Loss of training programs would likely lead to a deterioration of the quality of the medical personnel available to the geographic commander and adversely impact mission accomplishment.

Cost Factors of MHS Versus Private Health Care System

The Army, Navy, and Air Force operate about 465 military treatment facilities including 91 hospitals and 374 clinics.¹⁸ Tricare reported that they now have enrolled over 8.7 million beneficiaries. Tricare reported that the civilian network includes about 37,000 primary care managers (PCM's) and 134,000 specialists.¹⁹ The 8.7 million beneficiaries include the 1.38 million active duty troops.²⁰

In the private sector, which includes Tricare contractors, the cost of health care has been increasing for the past five decades.²¹ While a detailed discussion of health care costs is beyond the scope of this paper, a few observations are in order.

The argument in favor of trimming the MHS down to primarily respond to the readiness mission and greatly reducing its involvement with the benefits mission would likely be short sighted (for additional data see Appendix A). Three salient points to be made about contracting out the benefits mission are:

- Contracting out the benefits mission is unlikely to save money in the current environment and may actually be more expensive as contract providers are necessarily tied to the private health care system with its escalating cost.

- Contracting out the benefits mission further would entail a loss in training.
- Contracting out more is only a matter of degree since, as noted above,

Tricare currently utilizes 171,000 contract providers.

Part of the reason for increased cost of the MHS is that during the 1990's military health care was under funded. "As base medical facilities saw budgets get squeezed, they sent more and more of their patients "downtown" to use networks of Tricare civilian providers. However, network care costs much more than in-service care, a reality that forces health care costs ever higher."²² On 24 April 2001, General Shelton wrote a memo to Secretary of Defense Donald Rumsfeld stating that "not only is the military suffering from a decade of underfunding" but from "an inadequate management structure". He urged Rumsfeld to address this "not only as a near-term resource issue but as part of your transformation efforts".²³

One of the concerns expressed to this author by a senior Naval Medical Corps officer was that the current administration has expressed a desire to place even greater reliance on the private sector for medical care and drastically reduce the military's medical departments.²⁴

Advantages of Transforming to a Joint Medical Command - the Readiness Mission:

From the standpoint of the readiness mission of the MHS, a Joint Medical Command follows the principles of war adopted by the Armed Forces of the United States. It establishes unity of command. "The effective use of the nation's armed forces requires unity of effort in the direction and operation of diverse military resources."²⁵

Establishing a USMEDCOM along the lines of USSOCCOM and USTRANSCOM would facilitate the use of military medical assets by a geographic

commander. USMEDCOM would have overall vision and authority to plan, prioritize, and deploy the necessary assets. According to Joint Pub 4-0, geographic combatant commanders are responsible for “coordinating and integrating health service support”.²⁶ USMEDCOM would be available for integrated joint planning by the geographic combatant commanders and the other commands.

A USMEDCOM would be able to mass the health services assets more quickly by having an overview of all the military medical assets available. An example of being surge ready might be of mobilizing Army medical reserves to fill in gaps at a Naval hospital when a hospital ship is deployed. This would also reduce the adverse effects on the benefits mission. This particular example of capability would be dependent upon keeping the Reserve option desirable for medical personnel who do not wish to serve on a full-time basis. Being able to mass the MHS may be critical in the event that an adversary used weapons of mass destruction (WMD). Alluding to the experience of September 11, 2001, CAPT Fitzsimonds noted “the American military will play an even greater role in the deterrence and Consequence Management of any future use of WMD against U.S. interest”.²⁷ With the WMD, the possibility of tens and even hundreds of thousands of casualties exists. To achieve unity of purpose and to coordinate with other governmental agencies such as Homeland Security, unity of command may well be decisive. A further point in support of maintaining a robust benefits mission is that Consequence Management will require all of the primary and specialty care services that the MHS can muster.

Another principle of war applicable to USMEDCOM is maneuver. Senator Kennedy noted that “A biological attack would come like a thief in the night, spreading

through the population by stealth. A massive biological attack would be like no other threat the nation has ever faced, and our defenses against it must be just as unique. The front line soldiers in the war against bioterrorism will carry stethoscopes, not guns. They will drive ambulances, not tanks. And the front lines will be hospital wards and laboratory benches, not fields and battlements.”²⁸ Further he observed “Yet even the best defenses are useless if they cannot be deployed rapidly and effectively.”²⁹ Contract providers are not likely to respond as quickly as military medicine nor will there be sufficient numbers of contractors to meet such a challenge.

Another example of maneuver of the MHS is provided by the following tactical experience which leads to future operational planning and possibly doctrinal change. In Operation Iraqi Freedom, our forces faced an opponent who cared nothing for the Geneva conventions and hated the existence of our civilization. The big red cross on the side of our helicopter was not only a target for the enemy, but offensive to at least some of our allies. The Marines discovered that the best way to get our wounded off of the battle field was to forget those red crosses and use helicopters armed with a couple of 50 caliber machine guns. Specifically, the Marines in Iraqi Freedom dedicated several CH-46E Sea Knight helicopters to evacuate casualties from the point of wounding in hotly contested areas.³⁰ Perhaps the doctrine governing the rules of medical evacuation (ROME) need to be tailored to each operation much like the Rules of Engagement. And like the Rules of Engagement, they may need to be modified as the operation progresses. This is an example of a doctrinal consideration which should be made at the Joint Medical Command (USMEDCOM) level as it impacts all military services and the way we maneuver our forces.

The primary objective for the military health services is to promote, preserve and, to the extent possible, restore health (preserve the fighting force). A senior Naval Medical Corps officer stated that regardless of the branch of the service, “the mission is identical for all of the services”.³¹ Each service strives to deliver high quality medical care and must meet the exacting standards of medicine set in the civilian sector and monitored by JCAHO (Joint Commission on Accreditation of Hospitals Organization). Additional objectives are to provide humanitarian assistance and to care for noncombatants and wounded enemy troops. Doctors at U.S. Mobile Army Surgical Hospital 212 (MASH 212), which was in central Iraq during some of the fiercest fighting for Baghdad, reported on 6 April 2003 that approximately 60 per cent of the casualties they were treating were Iraqis.³² Similarly, the USS COMFORT was receiving Iraqi men, women, and children including wounded Iraqi soldiers during the war.³³

MHS is continually on the offensive in struggling with disease in times of peace. This aspect of medical services takes on vital urgency in a war torn area to prevent an outbreak of opportunistic diseases such as cholera and typhus which may quickly spread due to the deterioration of sanitary conditions and public services.

In consideration of economy of force, a recurrent theme from the senior level medical officers interviewed was the MHS need for greater standardization which would provide two advantages.³⁴ First, it would lead to cost savings through the economies of scale. Second, it would lead to far greater interoperability than exist today.³⁵ Standards of care are being addressed through Clinical Pathway Guidelines (CPGs), which are pre-conceived patient care algorithms, or paths, thought to be “able to standardize care for 60-70% of patients with a similar diagnosis, procedure or symptom.”³⁶ However, the

equipment for delivering care is not. A scalpel may be a scalpel, but even things as basic and critical as cardiopulmonary resuscitation (CPR) equipment vary from facility to facility. In fairness, part of this is due to rapid technological change coupled with budgetary constraints, but in large part this is simply due to a lack of centralized planning. This affects not only doctors and nurses but, also our medics and corpsmen. When it comes to critical items our medical personnel should know what's in the box even if they have just arrived. This is not to say that all items must be standardized. It is recognized that different localities will have differing needs and individual managers must continue to have latitude in their purchasing authority. Rather, it is to say that greater standardization is both feasible and desirable.

A USMEDCOM could actually save money by ending needless duplication in some areas. "I believe there are certain efficiencies to be gained by having a joint medical command. For instance, all the overhead of the surgeon's generals' offices could be consolidated; the detailing of folks could be done in a more coherent fashion and distributed more evenly to help gain financial solvency and personnel shops could be downsized by 2/3rds leaving more of us to see patients." ³⁷

In addition, USMEDCOM could facilitate communications and information exchange between facilities. Medical records transfers between commands for active duty members could be simplified and accomplished electronically and be available to the next treating unit or facility regardless of service branch. This would provide geographic commanders greater speed and flexibility in their decision cycle to deploy forces. It would be true even for those personnel in an area on a temporary duty basis.

A USMEDCOM combining assets could drive this cost down by fully exploiting informational technologies. It is estimated that processing a single transaction in the health care industry costs from \$ 12.00 to \$ 25.00. Administrative cost accounts for about one third of all health care spending. On a national basis, that is approximately \$ 400 billion per year. Banks and securities dealers over the past decade have reduced their transaction costs to pennies per transaction.³⁸ Tricare intends to move to all electronic billing in June 2003, despite some opposition among its contract providers.³⁹ Within the military portion of the MHS, the process is underway, but establishing a uniform combined system should lead to substantial cost savings in addition to providing the geographical commander with a MHS more capable of rapid response.

Arguments Against and Proposed Structure of a Joint Medical Command:

One of the frequently mentioned arguments against establishing a Joint Medical Command is the concern for the medical departments losing their individual Service's identity.⁴⁰ While an intimate understanding of the Service culture in which the medical service personnel operates is vitally important, there is nothing about a Joint Medical Command with individual Service components that would threaten that relationship. Prior to the establishment of USSOCOM similar concerns were expressed. But today Special Operations Forces of the Army, Navy and Air Force do not seem to be suffering any identity crisis to put it mildly. However, USSOCOM was mandated by Congress in 1987 "to correct serious deficiencies in the ability of the United States to conduct special operations and engage in low-intensity conflict activities."⁴¹ In essence, USSOCOM was formed in response to crises. One can only hope that this is not the only way a USMEDCOM can achieve the necessary political power to be established.⁴²

Further, the loss of identity issue assumes the so called purple suit concept. While the purple suit MHS does have some merit in its own right, two possible models presented in this paper render any idea of loss of identity at the tactical level as irrelevant. Figure 1 and Figure 2 give examples of possible USMEDCOM command structures.

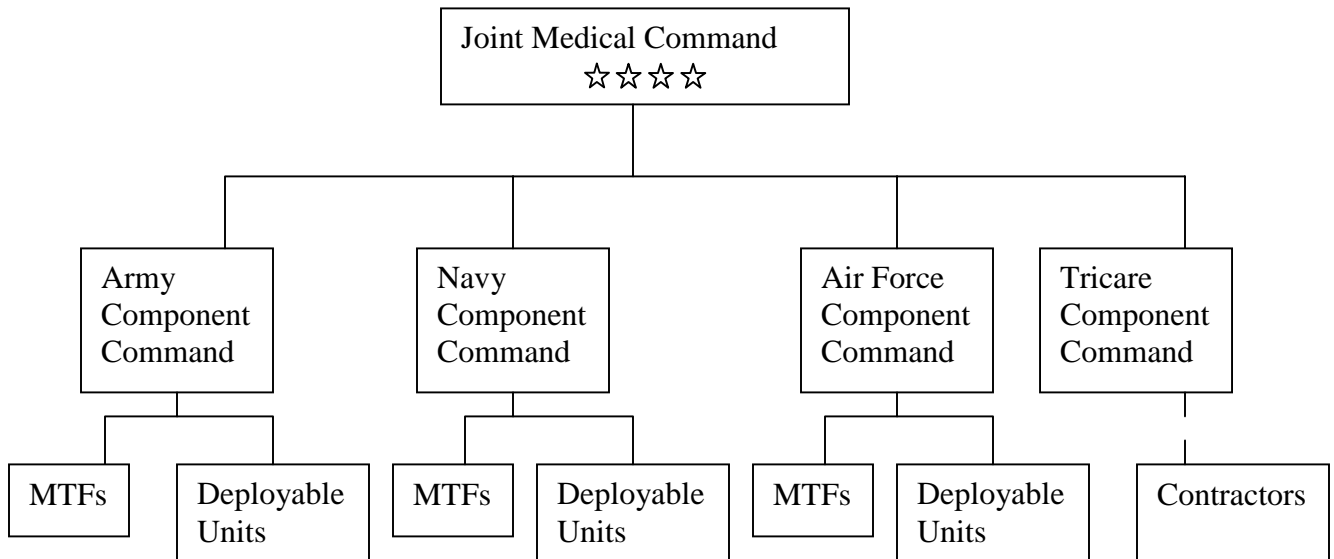


Figure 1

Figure 1 establishes a Joint Medical Command and retains much of the same structure of military medicine as it exists today. It puts Tricare on an equal footing with the individual service surgeon's generals. This notional model recognizes the importance and complexity of the beneficiary mission, but keeps it within the military health system. It maintains the military treatment facilities within the military and is the preferred model in this author's opinion.

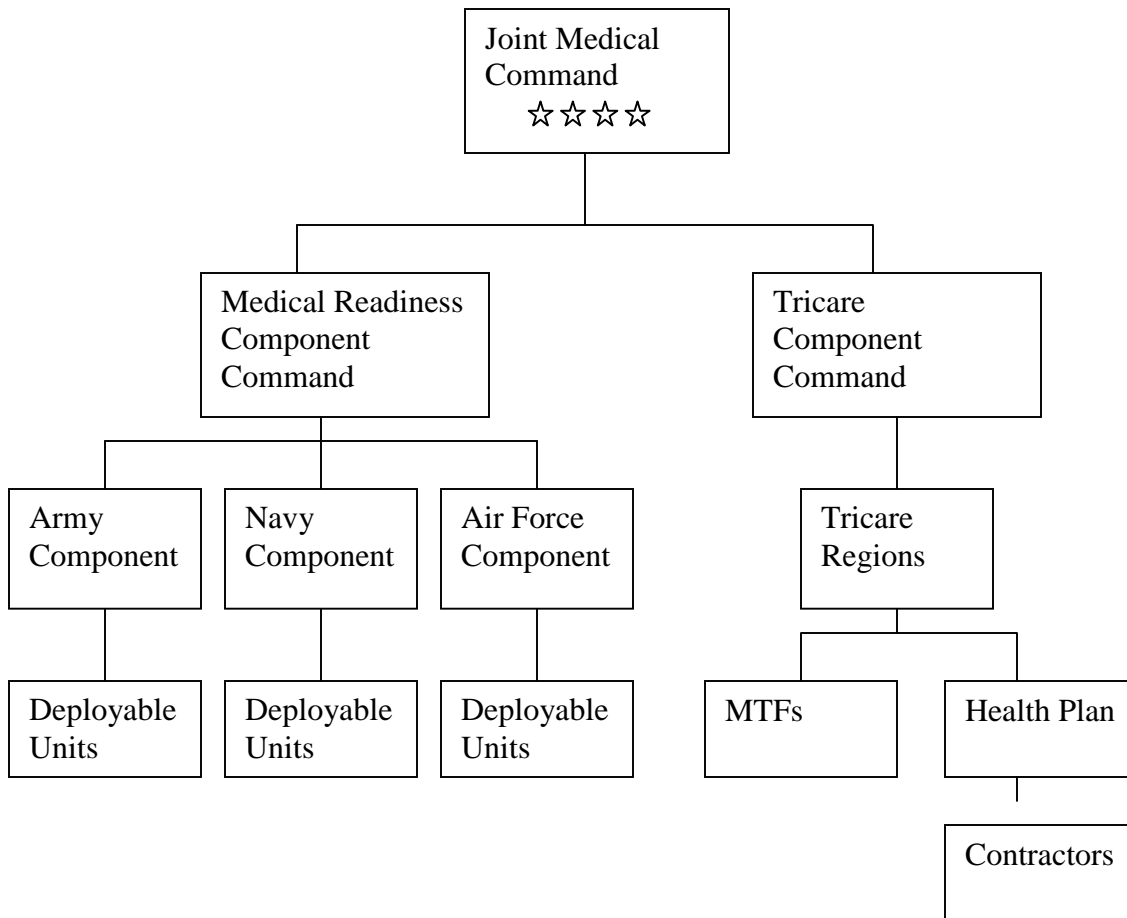


Figure 2

Figure 2 presented by the RAND study separates the readiness and beneficiary missions.⁴³ In this notional model, Tricare is made to perform on a “civilian-like” basis. Education and training are capital intensive ventures and rarely profitable in the near term. This of course explains why we have public schools as well as so many state and federally sponsored colleges and universities. Cutting the cost of education and training will likely be viewed by a dollar driven Tricare as easy targets to improve the bottom line and make Tricare appear to be more competitive with their civilian counterparts.

Another argument advanced against continuing a large military department (unified or not) was that we are the “only country left with a large medical department.”

⁴⁴ All the other major powers have paired their military medical services down to the bare essentials for combat. The problem with this view is that we have taken on global commitments far greater than any other major power. The scope and scale of our commitments may well involve us in situations that require a large MHS commensurate to the tasks. The United States prefers to have allies and form coalitions in support of combat operations and military operations other than war. Again to cite Joint Pub 4-0, “Multinational (allied and coalition) forces often require some support beyond their organic capabilities.” ⁴⁵ Further it notes, “logistic needs must be identified during the planning phase.” ⁴⁶ Health service support is a logistical consideration. USMEDCOM planners would likely be welcome partners to the geographic commander’s surgeon’s office.

One of the objections raised in the KPMG study was “Rotation policies for key positions may detract from longer tenure of high performers”. Transformation could easily address this issue. Longer tours of duties for health care personnel would decrease moving costs to the Department of Defense and the individual service member, improve continuity of care and increase retention of health care personnel.

Recommendations:

From the standpoint of the geographical commanders and even national security, the military health services should establish a Joint Medical Command. In addition, to meet growing asymmetric threats to our national security, the MHS should make it a goal of transformation to rely less on private contractors for health services and more on military medicine. In all probability, that would mean increasing the size of the force modestly, but as noted in the Transformation Planning Guidance the stakes are high, “If

the United States fails to transform, then our current military superiority and the relative peace, prosperity and stability it underwrites will erode.”⁴⁷

Conclusions:

The establishment of a Joint Medical Command, USMEDCOM, would offer the geographic commanders precisely what is required to achieve transformation from the perspective of Military Health Services (MHS). A single overall commander knowledgeable of the all of assets and capabilities available from the military health services would allow the comprehensive planning, prioritization, and distribution of forces to enable them to mass with the right mix of medical assets, at the right place, at the right time, across the battlespace and be capable of rapid decision superiority. Being joint would further enhance their ability to use network-centric command, control, communications, computers, timely intelligence and surveillance (C4IS). It would be better prepared to be “surge ready” than the existing system and should allow for developing greater options for the senior leadership by allowing greater flexibility in deploying assets to the combatant commanders.

Appendix A

The Department of Defense Appropriations Act, 2001 reported that medical and health care programs would be funded \$ 12.1 billion.⁴⁸ The total defense spending was estimated at \$ 291.1 billion. Therefore, approximately 4.16 % of the appropriations were earmarked for health care (though this figure does not reflect the total cost as a variety of costs are included under other accounts, nor does it include the individual services' contributions in the event of a shortfall in funding).

In the private sector, spending on health care services increased at the rate of 10 percent in 2001 and 8.8 percent in 2002, compared to the consumer Price Index (CPI) which increased 2.0 percent and 2.4 percent, during the same time frame.⁴⁹ Health care spending amounted to \$27 billion or 5.1 percent of the gross domestic product (GDP) in 1969. By 1980, health care spending increased to 9 percent of the GDP and by 1993, it had reached 13.7 percent.⁵⁰ The following table presents recent increases in health care relative to the GDP for the past 8 years.

Annual percentage change per capita in health care spending and GDP

Year	All Services	Hospital inpatient	Hospital outpatient	Physician	Prescription drugs	GDP
1995	2.2%	-3.5%	7.9%	1.7%	10.6%	3.7%
1996	2.0	-4.4	7.7	1.6	11.0	4.4
1997	3.3	-5.3	9.5	3.4	11.5	5.2
1998	5.3	-0.2	7.5	4.7	14.1	4.3
1999	7.1	1.6	10.2	5.0	18.4	4.4
2000	7.8	2.5	11.5	6.3	14.5	4.7
2001	10.0	7.1	16.3	6.7	13.8	1.4
2002	8.8	6.2	13.6	5.7	13.0	1.8

51

The greatest percentage gainers in health care cost immediately apparent are increases in the costs of hospital outpatient treatment and prescription drugs.

For the year 2003, it has been projected that “[The] average HMO (health maintenance organization) rate increase for active employees is 15 %. The HMO rate increases for retirees younger than 65 and retirees 65 and older exceed 20% [21% and 24%, respectively].”⁵²

Some of the reasons given for the increasing cost of health insurance premiums, which are in turn related to increased cost of health care are as follows:

- Aging of the population (actually accounts for less than 10% of increases)⁵³
- New medical technology
- Overuse and misuse of medical services
- Oversupply of health care facilities
- High administrative costs⁵⁴

The last four items on this list present the MHS with excellent opportunities. Transforming how we do business includes “a more entrepreneurial, future-oriented, capabilities-based resource allocation planning process”.⁵⁵ Entrepreneurs look for a competitive advantage in the market place. Military medicine has a number of potential advantages which need to be fully exploited.

One of the cost drivers fueling rising health care costs is administrative cost. A USMEDCOM combining assets could drive this cost down by fully exploiting informational technologies. It is estimated that processing a single transaction in the health care industry cost from \$ 12.00 - \$ 25.00. Administrative cost accounts for about one third of all health care spending, or on a national basis or approximately \$ 400 billion per year. Banks and securities dealers over the past decade have reduced their transaction

costs to pennies per transaction.⁵⁶ Tricare intends to move to all electronic billing in June 2003. However, it is noted that this may well be met with opposition amongst its contract providers.⁵⁷ Within the military portion of the MHS, the process is underway but establishing a uniform combined system should lead to substantial cost savings. Another example of exploiting information technology is the use of electronic prescriptions which not only reduce costs but improve quality of care by automatically alerting the prescribing provider of possible adverse drug interactions and the patient's recorded history of drug allergies. Unfortunately, contract providers are not included in this system which means the drugs written by a contract physician may or may not be known to the system.

Among the fastest rising costs in the health care industry is prescription drugs. Military medicine can and does save money using generic drugs whenever possible and by utilizing its volume buying power. For instance, the Department of Defense pays \$ 46.00 for a drug that retails for \$100.00.⁵⁸ A prescription drugs benefits program is currently a matter of a great deal of political debate and is beyond the scope of this paper. However, no matter how the debate turns out, this still is an area in which MHS has a competitive advantage.

In the private sector the purchase of expensive medical equipment often is based not on medical needs of the community, but to provide image for one hospital compared to its competitor across town. An example of this was noted by Henry E. Simmons, M.D. who stated, "There are cities in this country which have more MRI's and cat scanners than the nation of Canada. In these locations, the cost of care is 2-4 times higher than in

any other region of the country with no better outcomes.”⁵⁹ The MHS need purchase only the equipment required by the beneficiary population served.

Private health care has noted that the health care provided to uninsured, nonpaying, patients is a major factor in driving up costs. Caring for nonpaying patients leads to increasing the prices charged to insured, and paying patients (cost shifting).⁶⁰ Few of the patients treated by the MHS are uninsured. This should enable military medicine to hold down cost, but it does not apply to Tricare contractors.

Military providers do not have a financial incentive to perform unnecessary procedures and surgeries. In the private sector, including Tricare contract providers, this is not always the case. Similarly, the MHS is not motivated to build additional facilities to capture additional market share and drive out competition.

Finally, the last example of an advantage the MHS has, which is not available to the private sector, is its use of its splendid corpsmen and medics. These health care professionals perform a wide range of services from care on the battlefield to preventative medicine and health promotion activities in our hospitals and clinics.

NOTES

NOTES

-
- ¹ Vego, Milan N., OPERATIONAL WARFARE, NWC 1004.
- ² Family Voices Discusses: MANAGED CARE, <http://www.familyvoices.org/fs/msdiscussion.html>, 3 May 2003.
- ³ Strunk, Bradley C., et al., Tracking health care cost : growth accelerates again in 2001, Medical Benefits, Oct 30, 2002, Aspen Publishers, Inc..
- ⁴ Hosek, Susan D., and Cecchine, Gary, Reorganizing the Military Health System: Should There Be A Joint Command?, RAND, The National Defense Research Institute, 2001.
- ⁵ The Joint Staff Officer's Guide 2000, JFSC Pub 1.
- ⁶ The United States Department of Defense, Transformation Planning Guidance, April 2003.
- ⁷ Senior Navy leader who requested non-attribution, April 2003.
- ⁸ Office of The Surgeon General, Department of the Army, United States of America, Textbook of military Medicine, Medical Aspects of CHEMICAL AND BIOLOGICAL WAREFARE, 1997.
- ⁹ Wright, Homer J, The Economics of the Department of Defense Health Care System, U.S. Army War College, Carlisle Barracks, PA, 1992.
- ¹⁰ Dictionary of American Naval Fighting Ship, USS Comfort II (AH-6), Office of the Chief of Naval Operations, Naval History Division.
- ¹¹ Wehrly, David, Military Medicine Focused For Joint Warfighting, U.S. Army War College, Carlisle Barracks, PA, 1993.
- ¹² Hosek, Susan D., and Cecchine, Gary, 1.
- ¹³ Ibid. 75.
- ¹⁴ KPMG Consulting, DMOC III FINAL BRIEFING, 21 March 2001.
- ¹⁵ Hosek, Susan D., and Cecchine, Gary, 2.
- ¹⁶ Wehrly, David, Military Medicine Focused For Joint Warfighting, U.S. Army War College, Carlisle Barracks, PA, 1993.
- ¹⁷ Philpott, Tom, The Tricare Budget Drain, Air Force Magazine, August 2001.
- ¹⁸ Hosek, Susan D., and Cecchine, Gary, 2.
- ¹⁹ Kanof, Majorie, Oversight of the Adequacy of TRICARE's Civilian Provider Network Has Weakness, United States General Accounting Office, Testimony Before the Subcommittee on Armed Services, House of Representatives, United States General Accounting Office, March 27, 2003.
- ²⁰ Flourney, Michele A.(Editor), QDR 2001 Strategy-Driven Choices For America's Security, National Defense University Press, Washington, D.C. 2001.

-
- ²¹ Strunk, Bradley C., et al., Tracking health care cost : growth accelerates again in 2001, Medical Benefits, Oct 30, 2002, Aspen Publishers, Inc..
- ²² Philpott, Tom, The Tricare Budget Drain, Air Force Magazine, August 2001.
- ²³ Ibid..
- ²⁴ Personal interview with a US Naval Flag Officer who requested non-attribution.
- ²⁵ Joint Publication, Joint Doctrine Capstone and Keystone Primer, 10 September 2001.
- ²⁶ Joint Publication 4-0, Doctrine for Logistic Support of Joint Operations, 6 April 2000.
- ²⁷ Fitzsimonds, James, WEAPONS OF MASS DESTRUCTION: CONSIDERATIONS FOR THE OPERATIONAL COMMANDER, The United States Naval War College, NWC 2115B.
- ²⁸ Kennedy, Edward M. Remarks of Senator Edward M. Kennedy on Health Care, April 28, 2002.
- ²⁹ Ibid.
- ³⁰ Wall, Robert, Ordeal by Fire , Aviation Week & Space Technology, March 31, 2003.
- ³¹ Personal interview with a US Naval Flag Officer who requested non-attribution.
- ³² Sheridan, Mary Beth, On A Busy Night, Beds Fill Up With U.S. Soldiers, Iraqi POW's And Civilians, Washington Post, April 6, 2003.
- ³³ Sheridan, Mary Beth, On A Busy Night, Beds Fill Up With U.S. Soldiers, Iraqi POW's And Civilians, Washington Post, April 6, 2003.
- ³⁴ Thompson, Timothy, NWDC, Interview by author 31 March 2001.
- ³⁵ Personal interview with a US Naval Flag Officer who requested non-attribution.
- ³⁶ What are Clinical Pathways?, http://wwwsvh.stvincents.com.au/qi/Clin_Pathways/cp_what.htm, 5/13/03
- ³⁷ Sentell, John W., [JWSentell@sar.med.navy.mil], RE: Joint Medical Command, 4/1/2003.
- ³⁸ Kennedy, Edward M. Remarks of Senator Edward M. Kennedy on Health Care, April 28, 2002.
- ³⁹ Kanof, Majorie, Oversight of the Adequacy of TRICARE's Civilian Provider Network Has Weakness, United States General Accounting Office, Testimony Before the Subcommittee on Armed Services, House of Representatives, United States General Accounting Office, March 27, 2003.
- ⁴⁰ Casinelli, Paul E., 3.
- ⁴¹ USSOCOM, ORGANIZATION OVERVIEW.
- ⁴² Personal interview with a US Naval Flag Officer who requested non-attribution.
- ⁴³ Hosek, Susan D., and Cecchine, Gary, 21.

⁴⁴ Personal interview with a US Naval Flag Officer who requested non-attribution.

⁴⁵ Joint Publication 4-0, vii.

⁴⁶ Ibid.

⁴⁷ The United States Department of Defense, Transformation Planning Guidance, April 2003.

Selected Bibliography

Bailey, Ruby L., Prisoners, patients get care aboard ship, Detroit Free Press, April 11, 2003.

Buell, Barbara, The Chronic Search for a Health Care Cure, Stanford Business, November 1000, Volume 69, Number 1.

Casinelli, Paul E., THE JOINT MEDICAL COMMAND: BOON OR BUST FOR THE SUPPORTED CINC?, U. S. Naval War College, 18 May 2001.

Dictionary of American Naval Fighting Ship, USS Comfort II (AH-6), Office of the Chief of Naval Operations, Naval History Division.

Family Voices Discusses: MANAGED CARE,
<http://www.familyvoices.org/fs/msdiscussion.html>

Fitzsimonds, James, WEAPONS OF MASS DESTRUCTION: CONSIDERATIONS FOR THE OPERATIONAL COMMANDER, The United States Naval War College, NWC 2115B.

Flourney, Michele A.(Editor), QDR 2001 Strategy-Driven Choices For America's Security, National Defense University Press, Washington, D.C. 2001.

Hosek, Susan D. and Cecchine, Gary, Reorganizing the Military Health System : Should There Be A Joint Command?, RAND, The National Defense Research Institute, 2001.

Joint Publication, Joint Doctrine Capstone and Keystone Primer, 10 September 2001.

Joint Publication 4-0, Doctrine for Logistic Support of Joint Operations, 6 April 2000.

Kanof, Majorie, Oversight of the Adequacy of TRICARE's Civilian Provider Network Has Weakness, United States General Accounting Office, Testimony Before the Subcommittee on Armed Services, House of Representatives, United States General Accounting Office, March 27, 2003.

Kennedy, Edward M. Remarks of Senator Edward M. Kennedy on Health Care, April 28, 2002.

KPMG Consulting, DMOC III FINAL BRIEFING, 21 March 2001.

Musashe, Vincent, Deputy Chief of BUMED for Fleet Operations, Telephone interview with author, 31 March 2003.

Office of The Surgeon General, Department of the Army, United States of America, Textbook of military Medicine, Medical Aspects of CHEMICAL AND BIOLOGICAL WAREFARE, 1997.

Personal communication of US Naval Flag Officer who requested non-attribution.

Philpott, Tom, The Tricare Budget Drain, Air Force Magazine, August 2001.

Senior Navy leader who requested non-attribution, April 2003

Sentell, John W., [JWSentell@sar.med.navy.mil], RE: Joint Medical Command, 1 April 2003.

Sheridan, Mary Beth, On A Busy Night, Beds Fill Up With U.S. Soldiers, Iraqi POW's And Civilians, Washington Post, April 6, 2003.

Strunk, Bradley C., et al., Tracking health care cost : growth accelerates again in 2001, Medical Benefits, Oct 30, 2002, Aspen Publishers, Inc..

The Joint Staff Officer's Guide 2000, JFSC Pub 1.

The United States Department of Defense, Transformation Planning Guidance, April 2003.

Thompson, Timothy, NWDC, Interview by author 31 March 2001.

The United States Department of Defense, Transformation Planning Guidance, April 2003.

USSOCOM, ORGANIZATION OVERVIEW, 31 March 2003.

Vego, Milan N., OPERATIONAL WARFARE, NWC 1004.

Wall, Robert, Ordeal by Fire , Aviation Week & Space Technology, March 31, 2003.

Wehrly, David, Military Medicine Focused For Joint Warfighting, U.S. Army War College, Carlisle Barracks, PA, 1993.

What are Clinical Pathways?,
http://wwwsvh.stvincents.com.au/qi/Clin_Pathways/cp_what.htm, 5/13/03

Wright, Homer J, The Economics of the Department of Defense Health Care System, U.S. Army War College, Carlisle Barracks, PA, 1992.

-
- ⁴⁸ Public Law 106-259, 106th Congress, Department of Defense Appropriations Act, 2001, http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=106_cong_public_laws&doci...
- ⁴⁹ Strunk, Bradley C., et al., Tracking health care cost : growth accelerates again in 2001, Medical Benefits, Oct 30, 2002, Aspen Publishers, Inc.
- ⁵⁰ Buell, Barbara, The Chronic Search for a Health Care Cure, Stanford Business, November 1000, Volume 69, Number 1
- ⁵¹ Strunk, Bradley C., et al., Tracking health care cost : growth accelerates again in 2001, Medical Benefits, Oct 30, 2002, Aspen Publishers, Inc.
- ⁵² Towers, Perrin, 2003 health care cost survey : preliminary results, (Health Care Costs), Medical Benefits, Oct 30, 2002, Aspen Publishers, Inc.
- ⁵³ Strunk, Bradley C., et al., w305
- ⁵⁴ Miller, Joel E., Rising Health Insurance Premiums Will Increase Problems of Coverage and Quality, The National Coalition on Health Care, May 5, 2000
- ⁵⁵ The United States Department of Defense, Transformation Planning Guidance, April 2003
- ⁵⁶ Kennedy, Edward M. Remarks of Senator Edward M. Kennedy on Health Care, April 28, 2002
- ⁵⁷ United States General Accounting Office, DEFENSE HEALTH CARE: Oversight of the Adequacy of TRICARE's Civilian Provider Network Has Weaknesses, March 27, 2003
- ⁵⁸ Center For Policy Alternative, Prescription Drugs, March 26, 2003
- ⁵⁹ Simmons, Henry E., The Changing Health Care System and Its Impact on the Middle Class, address to the National Coalition on Health Care, September 4, 1997
- ⁶⁰ Ibid.